LOS ANGELES MEDICAL CENTER IPA

Health Education Referral Form

Fax to (951) 280-8218

A. Patient Information

Please verify patient's current address and phone number.		
Name:		Date of referral:
DOB:	Sex: ☐ M ☐	Language: ☐ ☐
Address:		
City:	Zip code:	Phone number:
If patient is a minor, please provide name and language of parent/legal guardian.		
Name:		Language: ☐ E ☐ S ☐ Other:
Diagnosis (include ICD-10 code) / Notes:		

B. Service Requested

☐ Class ☐ Support group ☐ One-to-one counseling* ☐ Health education material

Topic

☐ Age-Specific Ant. Guidance	☐ Family Planning	☐ Lead	☐ Obesity
☐ Asthma	☐ HIV/STD Prevention	☐ Poisoning	☐ Tobacco
☐ Breastfeeding	☐ Hypertension	☐ Nutrition	☐ Cessation
☐ Dental	☐ Immunizations	☐ Parenting	☐ Substance Abuse
☐ Diabetes	☐ Injury Prevention	☐ Perinatal/Pregnancy	Other:

C. Provider Information

Provider name:	
Person completing referral (if other than provider):	
Phone number:	Fax number:

LAMC IPA Health Education use only	
Referral Outcome	
Provider notification date:	